# *Patient Oral Evaluation*

Please take a moment to look at your teeth and gums and answer the following questions:

*Name:*________________________

*Date:*_________________________

1. Are your teeth crooked or crowded and is that a concern of yours? ____________
2. Do you have any spaces between your teeth that bother you? ____________
3. Do you like the color of your teeth? ____________
4. Do you like the shape of your teeth? ____________
5. If you had a magic wand, which of the following improvements would you make? Please circle.

    A. Lighten Teeth
    B. Lighten single tooth
    C. Close spaces between teeth
    D. Rebuild fracture (s)
    E. Lengthen
    F. Eliminate crowding
    G. Straighten
    H. Shorten
    I. Repair uneven edges
    J. Eliminate dark or stained fillings
    K. Reduce gums showing
    L. Other

6. On a scale of 1 to 10 (with 10 being best), how do you feel about your teeth? ____

Please add anything you feel is important:

_______________________________________________

_______________________________________________